VISION CARE PROVIDER HANDBOOK
APPENDICES

APPENDIX 1
VISION CARE SERVICES
PROCEDURE CODES AND COPAYMENT TABLE
(For Dates of Service On or After January 1, 1994)

Additional explanations of these codes and modifiers are contained in the CPT Procedure Code Book, which is available from the American Medical Association.

NOTE: Ophthalmologists may be reimbursed by the WMAP for all procedures with a single asterisk (*) indicated in this Appendix. Optometrists may be reimbursed for all procedures listed with a double asterisk (**) indicated. Only TPA-certified optometrists may be reimbursed for procedures requiring TPA certification. Opticians may be reimbursed only for procedures listed with a triple asterisk (***) pertaining to the dispensing and repair of eyeglasses.

Code	Description	Limitations	Copayment[1]
OFFICE OR OTHER OUTPATIENT SERVICES New Patient			
99201 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making	Once per recipient, per provider, per lifetime.	$1.00
99202 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	Once per recipient, per provider, per lifetime.	$1.00
99203 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity	Once per recipient, per provider, per lifetime.	$1.00
99204 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	Once per recipient, per provider, per lifetime.	$2.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99205 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Once per recipient, per provider, per lifetime. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$2.00
W8004 TOS J** *	Office visit, new patient; low vision	Once per recipient, per provider, per lifetime; prior authorization required.	$1.00
Established Patient			
99211 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician		$1.00
99212 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making		$1.00
99213 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity		$1.00
99214 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity		$1.00

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Code	Description	Limitations	Copayment[1]
99215 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$2.00
W8009 TOS J* TOS J**	Office visit, established patient; low vision	Prior authorization required.	$1.00
CONSULTATIONS			
99241 TOS J**	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99242 TOS J**	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examiniation; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99243 TOS J**	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity.	Referring physician information required on claim form.	$3.00
99244 TOS J**	Office consultation for a new of established patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	Referring physician information required on claim form.	$3.00

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Code	Description	Limitations	Copayment[1]
99245 TOS 3* TOS J**	Office consultation for a new or establihsed patient, which requires these three key components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
99251 TOS J**	Initial inpatient consultation for a new or establsihed patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99252 TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99253 TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components: a detailed history; a detailed examination; and medical decision making of low capacity.	Referring physician information required on claim form.	$3.00
99254 TOS J**	Initial inpatient consultation for a new or established patient, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	Referring physician information required on claim form.	$3.00
99255 TOS 3* TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00

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Code	Description	Limitations	Copayment[1]
99263 TOS 3* TOS J**	Follow-up inpatient consultation for an established patient which requires at least two of these three key components; a detailed interval history, a detailed examination; medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
99275 TOS 3* TOS J**	Confirmatory consultation for a patient, which requires these three key components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
HOME SERVICES New Patient			
99341 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	$1.00
99342 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requies these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity	Once per recipient, per provider, per lifetime.	$1.00
99343 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission. Once per recipient, per provider, per lifetime.	$1.00

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Code	Description	Limitations	Copayment[1]
Established Patient			
99351 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		$1.00
99352 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		$1.00
99353 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requies at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$1.00
HOSPITAL INPATIENT SERVICES Initial Hospital Care (New and Established Patient)			
99221 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making that is straightforward or of low complexity		$3.00
99222 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity		$3.00

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Code	Description	Limitations	Copayment[1]
99223 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key compoennts: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
Subsequent Hospital Care			
99231 TOS 1* TOS J**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a
99232 TOS 1* TOS J**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		n/a
99233 TOS 1* TOS J**	Subsequent hosptial care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
NURSING FACILITY SERVICES Comprehensive Nursing Facility Assessments (New or Established Patient)			
99301 TOS 1* TOS J**	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three components: a detailed interval history; a comprehensive evaluation; and medical decision making that is straightforward or of low complexity		n/a

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Code	Description	Limitations	Copayment[1]
99302 TOS 1* TOS J**	Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive evaluation; and medical decision making of moderate to high complexity		n/a
99303 TOS 1* TOS J**	Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission to the facility, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate to high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
Subsequent Nursing Facility Care (New or Established Patient)			
99311 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a
99312 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		n/a
99313 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of moderate to high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a

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Code	Description	Limitations	Copayment[1]
DOMICILIARY, REST HOME (e.g., BOARDING HOME), OR CUSTODIAL CARE SERVICES New Patient			
99321 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	n/a
99322 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	n/a
99323 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission. Once per recipient, per provider, per lifetime.	n/a
Established Patient			
99331 TOS 1* TOS J**	Domiciliary of rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a

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Code	Description	Limitations	Copayment[1]
99332 TOS 1* TOS J*	Domiciliary of rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; a expanded problem focused examination; and medical decision making that is straightforward of moderate complexity		
99333 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
EMERGENCY DEPARTMENT SERVICES New or Established Patient			
99281 TOS 1* TOS J*	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward		$1.00
99282 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward		$1.00
99283 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low to moderate complexity		$1.00

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Code	Description	Limitations	Copayment[1]
99284 TOS 1* TOS J**	Emergency department visit for the evaluation and mangement of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity		$1.00
99285 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient';s clinical condition and mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$1.00
GENERAL OPHTHALMOLOGICAL SERVICES New Patient			
92002 TOS 1* TOS J**	Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	Once per recipient, per provider, per lifetime.	$1.00
92004 TOS 1* TOS J**	Comprehensive, new patient, one or more visits	Once per recipient, per provider, per lifetime.	$2.00 (TOS J) $1.00 (TOS 1)
Established Patient			
92012 TOS 1* TOS J**	Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient		$1.00
92014 TOS 1* TOS J**	Comprehensive, established patient, one or more visits	Prior authorization required for more than one per recipient, per provider, per 12-month period.	$1.00
SPECIAL OPHTHALMOLOGICAL SERVICES			
92020 TOS B* TOS J**	Gonioscopy with medical diagnostic evaluation (separate procedure)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00

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Code	Description	Limitations	Copayment[1]
92060 TOS B* TOS J**	Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation (e.g., restrictive or paretic muscle with diplopia) (separate procedure)		n/a
92065 TOS B* TOS J**	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	Prior authorization required.	$1.00
92065-52 TOS B* TOS J**	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation, reduced service	Prior authorization required.	$1.00
VISUAL FIELDS			
92081 TOS B* TOS J**	Visual field examination, unilateral or bilateral, with medical diagnostic evaluation; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92082 TOS B* TOS J**	Intermediate examination (e.g., at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test; Octopus program 33)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
92083 TOS B* TOS J**	Extended examination (e.g., Goldmann visual fields with at least three isopters pltted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
TONOMETRY/TONOGRAPHY			
92100 TOS 1* TOS J**	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with medical diagnostic evaluation, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50

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Code	Description	Limitations	Copayment[1]
92120 TOS 1* TOS J**	Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92130 TOS 1* TOS J**	Tonography with water provocation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92140 TOS 1* TOS J**	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
OPHTHALMOSCOPY			
92225 TOS 1* TOS J**	Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; initial	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92226 TOS 1* TOS J**	Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; subsequent	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92250 92250-26 TOS 1* TOS J**	Ophthalmoscopy, with medical diagnostic evaluation; with fundus photography	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92260 92260-26 TOS 1* TOS J**	Ophthalmoscopy, with medical diagnostic evaluation; with ophthalmodynamometry	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92265 TOS B* TOS J**	Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation.	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00

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Code	Description	Limitations	Copayment[1]
ELECTRO-DIAGNOSTIC			
92270 TOS B* TOS J**	Electro-oculography, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	n/a
92280 92280-26 TOS B* TOS J**	Visually evoked potential (response) study, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
OTHER SPECIALIZED SERVICES			
92283 92283-26 TOS B* TOS J**	Color vision examination, extended (e.g., anomaloscope or equivalent)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
92284 92284-26 TOS B* TOS J**	Dark adaptation examination, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92285 92285-26 TOS B* TOS J**	External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92286 92286-26 TOS B* TOS J**	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
W8000 TOS J* TOS J** TOS J***	Ptosis Crutch (fitting and supply)	Prior authorization is required. Priced at prior authorization.	$1.00
W8001 TOS 1* TOS J** TOS J***	Therapeutic "Bandage" Lens (fitting and supply)	Not separately reimbursable in conjunction with 99201-99215	$1.00

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Code	Description	Limitations	Copayment[1]
CONTACT LENS AND THERAPY			
92310 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens both eyes, except for aphakia	Prior authorization required.	$3.00
92310-52 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens one eye, except for aphakia reduced service	Prior authorization required.	$3.00
92310-76 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens both eyes, except for aphakia, repeat procedure by same physician	Prior authorization required.	$3.00
92311 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye		$3.00
92311-22 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye, unusual service		$3.00
92312 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes		n/a
92312-22 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, unusual service		n/a
92312-52 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, reduced service		n/a

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Code	Description	Limitations	Copayment[1]
92312-76 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, repeat procedure by same physician		n/a
92326 TOS J* TOS J** TOS J***	Replacement of contact lens.	Prior authorization required unless provided for aphakia or keratoconus.	$3.00
92391 TOS J* TOS J** TOS J***	Supply of contact lenses, except prosthesis for aphakia (materials).	Prior authorization required unless provided for aphakia or keratoconus. Description required in the PA request indicating type of contact lenses being dispensed.	$3.00
OCULAR PROSTHESIS			
92330 TOS J* TOS J**	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation		n/a
92393 TOS J* TOS J** TOS J***	Supply of ocular prosthesis (artificial eye)		n/a
V2624 TOS J* TOS J** TOS J***	Polishing/resurfacing of ocular prosthesis		$1.00
DISPENSING/REPAIR/MATERIALS			
92340 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; monofocal		$3.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92341 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; bifocal		$3.00
92342 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; multifocal, other than bifocal		$3.00
92352 TOS J* TOS J** TOS J***	Fitting of spectacle prosthesis for aphakia; monofocal		$3.00
92353 TOS J* TOS J** TOS J***	Fitting of spectacle prosthesis for aphakia; multifocal		$3.00
W8191 TOS J* TOS J** TOS J***	Minor repair		$.50
W8525 TOS J* TOS J** TOS J***	Lens replacement, unifocal, dispensing fee		$2.00
V2118 TOS J* TOS J** TOS J***	Aniseikonic lens, single vision (materials)	Prior authorization required, priced at prior authorization	$1.00
V2799 TOS J* TOS J** TOS J***	Non-contracted materials	Prior authorization required, priced at prior authorization. A copy of the catalog page is required indicating materials dispensed and cost of item(s).	n/a

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
W8520 TOS J* TOS J** TOS J***	Frame replacement, dispensing fee		$2.00
W8522 TOS J* TOS J** TOS J***	Temple replacement, dispensing fee		$2.00
W8190 TOS J* TOS J** TOS J***	Dispensing of non-contracted materials and other miscellaneous services	Prior authorization required, priced at prior authorization	n/a
W8112 TOS J* TOS J** TOS J***	Fitting of spectacles, changed prescription, complete appliance, single vision	A change in the lens prescription of more than +/-.50 diopter in the spherical or cylinder power must be documented in the recipient's medical record. The WMAP only reimburses one of these procedures, per provider, per recipient, per 12-month period.	$3.00
W8113 TOS J* TOS J** TOS J***	Fitting of spectacles, changed prescription, complete appliance, bifocal or multifocal		$3.00
W8523 TOS J* TOS J** TOS J***	Lens replacement, changed prescription, single vision, dispensing fee		$2.00
W8524 TOS J* TOS J** TOS J***	Lens replacement, changed prescription, bifocal or multifocal, dispensing fee		$2.00
LOW VISION SERVICES			
92354 TOS J* TOS J** TOS J***	Fitting of spectacle mounted low vision aid; single element system (dispensing fee)	Prior authorization required	$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92355 TOS J* TOS J** TOS J***	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system (dispensing fee)	Prior authorization required	$1.00
V2600 TOS J* TOS J** TOS J***	Hand held low vision aids and other non-spectacle mounted aids (materials)	Prior authorization required, priced at prior authorization	$1.00
V2610 TOS J* TOS J** TOS J***	Single lens spectacle mounted low vision aids (materials)	Prior authorization required, priced at prior authorization	$1.00
V2615 TOS J* TOS J** TOS J***	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens sytem (materials)	Prior authorization required, priced at prior authorization	$1.00
REFRACTION SERVICES (for crossover claims only)			
92015 TOS 1* TOS J**	Determination of refractive state		n/a
VESTIBULAR FUNCTION TESTS			
92531 TOS B* TOS J**	Spontaneous nystagmus, including gaze	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92532 TOS B* TOS J**	Postitional nystagmus	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92533 TOS B* TOS J**	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92534 TOS B* TOS J**	Optokinetic nystagmus	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
EYEBALL			
65205 TOS 2* TOS J**	Removal of foreign body, external eye; conjunctival superficial	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65210 TOS 2* TOS J**	Conunctival embedded (includes concretions), subconunctival, or scleral nonperforating	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65220 TOS 2* TOS J**	Corneal, without slit lamp	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65222 TOS 2* TOS J**	Corneal, with slit lamp	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
ANTERIOR SEGMENT CORNEA			
65430 TOS 2* TOS J**	Scraping of cornea; diagnostic, for smear and/or culture	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65435 TOS 2* TOS J**	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65436 TOS 2* TOS J**	With application of chelating agent (e.g., EDTA)	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OCULAR ADNEXA-EYELIDS			
67820 TOS 2* TOS J**	Correction of trichiasis; epilation, by forceps only		$3.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
67825 TOS 2* TOS J**	Epilation (e.g., by electrosurgery or cryotherapy)		$3.00
67938 TOS 2* TOS J**	Removal of embedded foreign body, eyelid	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OCULAR ADNEXA-LACRIMAL SYSTEM			
68800 TOS 2* TOS J**	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
68820 TOS 2* TOS J**	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
68840 TOS 2* TOS J**	Probing of lacrimal canaliculi, with or without irrigation	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OPHTHALMIC ULTRASOUND			
76511 76511-26 TOS 4* TOS Q* TOS J**	Ophthalmic ultrasound, echography diagnostic; A-scan only, with amplitude quantification	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76512 76512-26 TOS 4* TOS Q* TOS J**	Contact B-scan (with or without simultaneous A-scan)	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76516 76516-26 TOS 4* TOS Q* TOS J**	Ophthalmic biometry by ultrasound echography, A-scan	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
76519 76519-26 TOS 4* TOS Q* TOS J**	With intraocular lens power calculation	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76529 76529-26 TOS 4* TOS Q* TOS J**	Ophthalmic ultrasonic foreign body localization	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92499 TOS J* TOS J**	Unlisted ophthalmological service or procedure	Description required of the service(s) or procedure(s) provided.	n/a
MISCELLANEOUS SERVICES			
99000 TOS 1* TOS J**	Laboratory handling fee	Only allowable for ophthalmologists and TPA-certified optometrists	n/a

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

APPENDIX 2
LENSES AVAILABLE THROUGH THE WISCONSIN MEDICAL ASSISTANCE STATE PURCHASE EYEGLASS CONTRACT

Single Vision

Minus Cylinder Corrected Curve

Bifocals

Flattop
Round Top
One Piece Flattop (Executive Style)

Trifocals

Flattop
One Piece Flattop (Executive Style)

Cataract Lenses

Full Field Aspheric
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Lenticular Aspheric
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Non-Aspheric Lenticular
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Lens Components in Addition to Lens Formula

Extra Thick Blanks
High Index Glass or Plastic*
Large Blanks (59 mm eye size & over)*
Myodisc
Photochromic (Photograys, etc.*)
Special Base Curve
Cylinders 3.25 to 6.00D
Cylinders 6.25 and above
Prism
Tinted Eyeglass lenses (rose tints 1 and 2)*
Polycarbonate Lenses**
Slab Off Prism
Ultraviolet Protective Coating*
Minus over 20.00D (add to 12.25 to 20.00D)

* These items require prior authorization before ordering from the SPEC contractor.
** This item requires prior authorization for recipients age 21 and over.

APPENDIX 3
FRAMES AVAILABLE THROUGH
STATE PURCHASE EYEGLASS CONTRACT

Womens' Frames
RO 204 (Rochester)
RO 604 (Rochester)
RO 151 (Rochester)
Mainstreet 220 (Hart Spec.)
Jenny (Hart Spec.)
RO 275 (Rochester)
Justafit 3 (Pathway)
Boulevard 3112 (Hart Spec.)
Mainstreet 962 (Hart Spec.)

Girl's Frames
Mainstreet 401 (Hart Spec.)
Mainstreet 403 (Hart Spec.)
Jenny (Hart Spec.)
Justa-Fit 4 (Pathway)
Mainstreet 229 (Hart Spec.)
Mainstreet 885 (Hart Spec.)
Boulevard 3115 (Hart Spec.)

Infant's Frames
Teddy Bear (Tart)

Unisex Half-Eye
Mainstreet Looker

Men's Frames
Passport 14 (Artcraft)
RO 401 (Rochester)
RO 524 (Rochester)
Mainstreet 106 (Hart Spec.)
Boulevard 1003 (Hart Spec.)
Mainstreet 302 (Hart Spec.)
Mainstreet 859 (Hart Spec.)
Boulevard 1015 (Hart Spec.)

Boy's Frames
Boulevard 3013 (Hart Spec.)
Skipper (Tart)
Mainstreet 304 (Hart Spec.)
Baby (Hart Spec.)
RO 200 (Rochester)
Starwalker Combination (Martin-Copeland)
Mainstreet 302 (spring hinge) (Hart Spec.)

Occupational Frames
SP 83

APPENDIX 4
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS FOR VISION SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator in the Medicaid check box. Enter claim sort indicator "P" for ophthalmologist for diagnostic services. Enter "V" for an ophthalmologist when billing for services related to materials, dispensing and repair, or for any service by an optometrist or optician. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is 10 days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4, enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's 10-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed because for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services provided by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers must describe the procedure. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB
If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 11 of this handbook for a list of allowable place of service codes for vision providers.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code. Refer to Appendix 11 of this handbook for a list of allowable type of service codes for vision providers.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. Refer to Appendix 1 of this handbook for a list of allowable procedure codes for vision providers.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck or family planning does not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 5
NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE [ ] (Medicare #) | MEDICAID [ ] (Medicaid #) | CHAMPUS [ ] (Sponsor's SSN) | CHAMPVA [ ] (VA File #) | GROUP HEALTH PLAN [ ] (SSN or ID) | FECA BLK LUNG [ ] (SSN) | OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A

3 PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [ ] F [X]

4 INSURED'S NAME (Last Name, First Name, Middle Initial):

5 PATIENT'S ADDRESS (No., Street): 609 Willow St.

6 PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8 PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: | STATE:

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY:

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY:

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 76543210

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY:

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 365.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 02 92		3	J	99213		1	XX XX	1				87654321
2 01 02 92		3	J	92083		1	XX XX	2				87654321
3 01 02 92		3	J	92100		1	XX XX	2				87654321
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized

MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 65432109

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX 6
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR VISION SERVICES

ELEMENT 1 - PROCESSING TYPE
Enter the three-digit processing type 122 (vision).

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis of V53.1 cannot be used as the primary or sole diagnosis.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service/procedure/item requested, in this element.

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medical Assistance Program [WMAP] policy and the coding structure used) for each service/procedure/item requested.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 11 for allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. Refer to Appendix 11 for allowable type of service codes.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure/item requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 7
PRIOR AUTHORIZATION REQUEST FORM

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 122

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow
Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider O.D.
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 366.9 Cataract

11 DX: SECONDARY: 368.13 Photophobia

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8110		3	J	Photochromic Lenses	1	LAB
					TOTAL CHARGE	21 LAB

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I. M. Provider, O. D. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 8
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION VISION ATTACHMENT (PA/VA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete the Prior Authorization Vision Attachment (PA/VA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the PA/RF and/or the PA/VA may be addressed to the EDS Telephone/ Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENTS' FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S NUMERICAL AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

ELEMENT 6 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the name of the referring/prescribing provider, if available.

ELEMENT 7 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

ELEMENT 8 - PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code of the provider providing/dispensing the service/item.

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D, which are pertinent to the request.

2. Lens formula information is required for all requests for frames or lenses (Element A).

3. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

4. Specify the type of contacts prescribed.

5. Date and sign the attachment (Element E).

APPENDIX 9
PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT (PA/VA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/VA

PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

1	2	3	4	5
Recipient	Ima	A	1234567890	65
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
I.M. Provider, O.D.	88888888	(XXX) XXX . XXXX
REFERRING/PRESCRIBING PROVIDER'S NAME	REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER

A. LENSES AND FRAMES

NOTE: Lens formula information is required for all requests for frames or lenses

LENS FORMULA: (L) +1.50-- ADD+2.75
(R) +1.50--

☐ REPLACEMENT ONLY

FRAME NAME: Far Horizon 94
FRAME MANUFACTURER: Martin-Copleland
☐ REPLACEMENT ONLY

☒ COMPLETE APPLIANCE (Lenses and frames)

B. SPECIAL LENS/FRAME REQUEST:

☐ Oversize
☐ Add over +.4.00
☐ Patient supplied frame
☒ Contract lab supplied frame
☐ Non-contract frame (Not supplied by recipient)

Justification for Non-Contract Frame:

(Principle justification may not be cosmetic; principle justification must be medically/visually necessity)

☐ Other (provide pertinent history /findings and justification along with specifics of request)

If request is for a non-contract item, estimate wholesale cost:

C. **TINTS:**

(All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation is insufficient justification.)

☐ Rose 1 ☐ Rose 2 ☒ Photochromic

☐ Other tint (explain)

Justification for tint (See above)

Recipient has cortical cataracts which are causing excessive glare and light sensitivity. Photochromic lenses will help eliminate this glare and allow the recipient's visual system to function more effectively.

D. **OTHER VISION SERVICE REQUESTED:**

Service Requested:

Pertinent history/findings and justification:

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

E. MM/DD/YY
Date

J. M. Provider, O.D.
Requesting/Performing Provider's Signature

APPENDIX 10
FREQUENTLY USED DIAGNOSIS CODES

Frequently used ICD-9-CM diagnosis codes and descriptions pertaining to vision care:

361	Detached Retina
362	Other Retinal Disorders
362.1	Other Background Retinopathy and Retinal Vascular Changes
365	Glaucoma
366.9	Cataract
367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.4	Presbyopia
368.0	Amblyopia ex anopsia
368.1	Subjective Visual Disturbances
368.5	Color Blindness
368.6	Night Blindness
369.3	Unqualified Visual Loss (both eyes)
371	Corneal Opacity
371.6	Keratoconus
374.3	Ptosis of Eyelid
374.9	Unspecified Disorder of Eyelid
377.0	Papilledema
377.1	Optic Atrophy
378.0	Esotropia
378.1	Exotropia
378.31	Hypertropia
379.3	Aphakia and Other Disorders of Lens
V72.0	Annual Eye Exam (when done for a routine purpose, such as to check eyeglass prescription)
V53.1	Fitting, Adjustment or Replacement Glasses

Opticians should use V53.1 (Fitting, Adjustment or Replacement Glasses) when dispensing eyeglasses which have been prescribed by another provider.

NOTE: V53.1 cannot be used as either the primary or sole diagnosis on a prior authorization request form.

APPENDIX 11
ALLOWABLE VISION CARE PLACE OF SERVICE (POS) CODES AND TYPE OF SERVICE (TOS) CODES FOR VISION CARE PROCEDURE CODES

POS	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
B	Ambulatory Surgery Center

TOS	
J	Vision Services (including all optometrist and optician services, as well as dispensing, materials and repair by an ophthalmologist)
1	Medical Care (ophthalmologist only)
2	Surgery (ophthalmologist only)
3	Consultations
4	Ultrasound Total or Complete Procedure (including professional and technical components)
Q	Ultrasound Professional Component (interpretation)

APPENDIX 12
WMAP COVERED DRUGS

A. COVERED DRUGS - LEGEND DRUGS

The WMAP uses an Open Formulary for legend drugs with few restrictions. Restrictions include:
Drugs Which Require Prior Authorization (See Sections C and D below), Noncovered Manufacturer Drugs (see Section A of Appendix 29 of this handbook), Less-Than-Effective Drugs (See Section B of Appendix 29 of this handbook) and Negative Formulary Drugs (See Section C of Appendix 29 of this handbook).

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS

WMAP covered over-the-counter drugs are limited to ONLY the following categories:

ANALGESICS-ORAL/RECTAL[1]	COUGH SYRUPS[2]	INSULIN
ANTACIDS	FERROUS GLUCONATE/SULFATE FOR PREGNANT WOMEN	OPHTHALMIC LUBRICANTS
CONTRACEPTIVE SUPPLIES		

(*NOTE:* Coverage is limited to generic drugs for all covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are NOT covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Mylanta, Rolaids, Clear Tears, Lyteers, Neo Tears, Maalox, Titralac, Ecotrin, Robitussin, Tylenol, Ascriptin, Riopan and Advil.)

C. COVERED NON REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs require prior authorization because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to the WMAP which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement.

Generic equivalents of these drugs are not included in this requirement and may be billed without prior authorization if the generic manufacturer has signed a rebate agreement.

DALMANE	LIBRIUM	QUARZAN	TRANS-PLANTAR
EIGHT MOP	MELANEX	RIMSO 50	VALIUM
LIBRITABS	MENRIUM	TRANS-VER-SAL	

---

1 Limited to single entity aspirin, acetaminophen, ibuprofen products only.

2 Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs are produced by manufacturers which have signed rebate agreements but require prior authorization to determine medical necessity. Diagnosis and information regarding the medical requirements for these drugs must be provided on the prior authorization request.

CS III & IV STIMULANTS
(Excludes Mazindol)
Benzphetamine
Diethylpropion
Fenfluramine
Phendimetrazine
Phentermine

ENTERAL NUTRITIONALS
Ensure, Pediasure
Meritine, Enrich
Sustacal, etc.

EPOETIN ALFA
Epogen, Procrit

LACTULOSE
Cephulac, Chronulac
Enulose, etc.

HUMAN GROWTH HORMONE
Humatrope
Protropin

CLOZAPINE
Clozaril

HYPERALIMENTATION
Total Parenteral Nutrition
Peripheral Parenteral Nutrition

UNLISTED/ INVESTIGATIONAL DRUGS
Biopterin (tetrahydrobiopterin)
Somogard (deslorelin)

ALPHA-1-PROTEINASE INHIBITOR
Prolastin

MUROMONAB-CD3
Orthoclone OKT3

INTERFERON
Alferon N, Intron-A
Roferon-A

DIPYRIDAMOLE (07/01/92)
Persantine

ALGLUCERASE (11/1/92)
Ceredase

TICLOPIDINE (11/1/92)
Ticlid

APPENDIX 13
WMAP NONCOVERED DRUGS

A. *NONCOVERED DRUGS - NO MANUFACTURER REBATE AGREEMENT*

Manufacturers of the following drugs have chosen not to participate in the Medicaid program. This is not a complete list of noncovered drugs. This list may change if manufacturers sign rebate agreements. Prior Authorization will NOT be granted for these drugs. Generic alternatives for these drugs are covered if the manufacturer signed a rebate agreement.

AEROLATE	DUOLUBE	KARIDIUM	NAFRINSE	XERAC AC
ASTHMANEPHRINE	EPPY N OPTH SOLN	KARIGEL	NEO-TEARS	YODOXIN
BICHLORACETIC ACID	EPPY SOL OPH	LYTEERS	PIMA	
CLEAR TEARS	EXTENDRYL	MOISTURE DROPS	RUM-K	
DRYSOL	FLUORITAB	MONOJECT INSULIN JEL	TINVER LOTION	

B. *WMAP NONCOVERED DRUGS - FDA LESS-THAN-EFFECTIVE DRUGS.*

Prior Authorization will not be granted for these drugs nor for any generic alternatives identified by the Food and Drug Administration (FDA) as identical, related or similar to these drugs. This list represents only the most commonly prescribed LTE drugs.

AMESEC	DEPROL	KINESED	MUDRANE	QUIBRON PLUS
ARLIDIN	DONNATAL	LEVSIN W PHENOBARB	NALDECON	RAUTRAX
BELLABARB	DONNATAL EXTENTABS	LIBRAX	NYLIDRIN	THEOFED
BELLADENAL	ENTEX	LUFYLLIN EPG	PENTAERYTHRITOL TN	TIGAN ORAL/RECTAL
BELLADENAL S	ENTEX LIQ	MARAX	PERITRATE	TUSS ORNADE
BELLERGAL S	FEDRINAL	MEPERGAN FORTIS	PHENOBARB & BELLADONNA	VASODILAN
BUTIBEL	ISOLATE COMP	MIDRIN	PRISCOLINE	VIOFORM W HC
CYCLANDELATE	ISOXUPRINE	P.V. TUSSIN	QUADRINAL	VYTONE

C. *WMAP NONCOVERED DRUGS - WISCONSIN NEGATIVE FORMULARY*

Prior Authorization will not be granted for these drugs.

ALGINATE	MINOXIDIL TOPICAL	PROGESTERONE FOR PMS
GAVISCON	NON REBATED DRUGS INELIGIBLE FOR PA	LEGEND MULTI-VITAMINS (NON PRENATAL)